



IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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PHONE 208-334-6626
FAX 208-364-1888

July 25, 2006

Anne Oglevie, Administrator
Weiser Memorial Home Health Agency - Provider #137076
645 E 5th
Weiser, ID 83672

Dear Ms. Oglevie:

On July 11, 2006, a follow-up visit of your agency was conducted to verify correction of deficiencies noted during the Annual Licensure survey of June 2, 2006. Weiser Memorial Home Health Agency was found to be in substantial compliance as of July 11, 2006.

Your copy of the Post-Licensure Revisit Report, Form 2567B, listing deficiencies that have been corrected is enclosed. This is for your information only and need not be returned.

Thank you for the courtesies extended to us during our visit. If we can be of any help to you, please feel free to call us at 334-6626.

Sincerely,

DEB DORE'
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

DD/SC/slc

Enclosures

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 137076	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 7/11/2006
Name of Facility WEISER MEMORIAL HOME HEALTH		Street Address, City, State, Zip Code 36 E IDAHO ST UNIT #R2 WEISER, ID 83672

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ID Prefix <u>G0122</u> Reg. # <u>484.14</u> LSC _____	Correction Completed 07/11/2006	ID Prefix <u>G0128</u> Reg. # <u>484.14(b)</u> LSC _____	Correction Completed 07/11/2006	ID Prefix <u>G0130</u> Reg. # <u>484.14(b)</u> LSC _____	Correction Completed 07/11/2006
ID Prefix <u>G0133</u> Reg. # <u>484.14(c)</u> LSC _____	Correction Completed 07/11/2006	ID Prefix <u>G0142</u> Reg. # <u>484.14(f)</u> LSC _____	Correction Completed 07/11/2006	ID Prefix <u>G0144</u> Reg. # <u>484.14(a)</u> LSC _____	Correction Completed 07/11/2006
ID Prefix <u>G0151</u> Reg. # <u>484.16</u> LSC _____	Correction Completed 07/11/2006	ID Prefix <u>G0153</u> Reg. # <u>484.16</u> LSC _____	Correction Completed 07/11/2006	ID Prefix <u>G0154</u> Reg. # <u>484.16(a)</u> LSC _____	Correction Completed 07/11/2006
ID Prefix <u>G0156</u> Reg. # <u>484.18</u> LSC _____	Correction Completed 07/11/2006	ID Prefix <u>G0160</u> Reg. # <u>484.18(a)</u> LSC _____	Correction Completed 07/11/2006	ID Prefix <u>G0161</u> Reg. # <u>484.18(a)</u> LSC _____	Correction Completed 07/11/2006
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Reviewed By <u>IR</u> State Agency	Reviewed By <u>SC</u>	Date: <u>7/17/06</u>	Signature of Surveyor: <u>[Signature]</u> RN	Date: <u>7/14/06</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

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ID Prefix <u>G0242</u> Reg. # <u>484.52</u> LSC _____	Correction Completed 07/11/2006	ID Prefix <u>G0244</u> Reg. # <u>484.52</u> LSC _____	Correction Completed 07/11/2006	ID Prefix <u>G0245</u> Reg. # <u>484.52</u> LSC _____	Correction Completed 07/11/2006
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Reviewed By <u>JD</u> State Agency	Reviewed By <u>SC</u>	Date: <u>7/17/06</u>	Signature of Surveyor: <u>[Signature]</u>	Date: <u>7/14/06</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on:
6/2/2006

Check for any Uncorrected Deficiencies. Was a Summary of
Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9U5V

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: OAS001670

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 137076		3. NAME AND ADDRESS OF FACILITY (L3) WEISER MEMORIAL HOME HEALTH (L4) 36 E IDAHO ST UNIT #R2 (L5) WEISER, ID (L6) 83672		4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Termination of ICF Beds	
2. STATE VENDOR OR MEDICAID NO. (L2) 002851700		7. PROVIDER/SUPPLIER CATEGORY <u>05</u> (L7) 01 Hospital 05 HHA 09 ESRD 13 PTIP 02 SNF/NF/Dual 06 LAB 10 NF 14 CORF 03 SNF/NF/Distinct 07 X-Ray 11 IMR 15 ASC 04 SNF 08 OPT/SP 12 RHC 16 HOSPICE		FISCAL YEAR ENDING DATE: (L35) 06/30	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 7/11/06		6. DATE OF SURVEY 06/02/2006 (L34)		8. ACCREDITATION STATUS: <u>0</u> (L10) 0 UNACCREDITED 1 JCAHO 2 CHAP	
11. LTC PERIOD OF CERTIFICATION From (a): To (b):		10. THE FACILITY IS CERTIFIED AS: X A. In Compliance With Program Requirements Compliance Based On: ___ 1. Acceptable POC ___ 2. Technical Personnel ___ 3. 24 Hour RN ___ 4. 7-Day RN (Rural SNF) ___ 5. Life Safety Code ___ 6. Scope of Services Limit ___ 7. Medical Director ___ 8. Patient Room Size ___ 9. Beds/Room And/Or Approved Waivers Of The Following Requirements: B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A* (L12)			
12. Total Facility Beds (L18)		13. Total Certified Beds (L17)		14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IMR (L37) (L38) (L39) (L42) (L43)	
15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)		16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): Recertification Recommended			

17. SURVEYOR SIGNATURE

Date:

18. STATE SURVEY AGENCY APPROVAL

Date:

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY <input checked="" type="checkbox"/> 1. Facility is Eligible to Participate <input type="checkbox"/> 2. Facility is not Eligible (L21)		20. COMPLIANCE WITH CIVIL RIGHTS ACT: Y		21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : _____	
22. ORIGINAL DATE OF PARTICIPATION 07/07/1994 (L24)		23. LTC AGREEMENT BEGINNING DATE (L41)		24. LTC AGREEMENT ENDING DATE (L25)	
25. LTC EXTENSION DATE: (L27)		27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44) B. Rescind Suspension Date: (L45)		26. TERMINATION ACTION: (L30) VOLUNTARY <u>00</u> 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination OTHER 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active	
28. TERMINATION DATE:		29. INTERMEDIARY/CARRIER NO. 00454 (L28)		30. REMARKS (L31)	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE (L33)		DETERMINATION APPROVAL	

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6/2/2006

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